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THE URBAN INDIAN HEALTH EQUITY ACT

OCTOBER 26 (legislative day, OCTOBER 2), 1990.—Ordered to be printed

Mr. INOUE, from the Select Committee on Indian Affairs,
submitted the following

REPORT

[To accompany S. 2645]

The Select Committee on Indian Affairs, to which was referred the bill (S. 2645) to improve the health status of the urban Indian population and to enhance the quality and scope of health care services, disease prevention activities, and health promotion initiatives targeted at the urban Indian population, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

PURPOSE

The purpose of the bill is to improve the health status of the urban Indian population and to enhance the quality and scope of health care services, disease prevention activities, and health promotion initiatives targeted at the urban Indian population.

BACKGROUND AND NEED

In 1980, the U.S. Census data indicated that over 50 percent of the 1.4 million American Indians resided in urban areas. The total Indian population may have increased to nearly 2.5 million in 1990 and early indicators would suggest that nearly 1.2 million Indian persons may reside in urban settings. Much of this growth in the urban Indian population can be attributed to high unemployment in reservation communities and the relocation of Indian people seeking better employment or educational opportunities. In fact many of the urban Indians who have relocated to urban areas and remain in these communities were strongly urged to relocate off the reservation during the termination era of the 1950's and 1960's. Relocation was an aggressive Federal Indian policy intended to in-

tegrate Indians into urban American society and complemented other termination programs designed to promote the rapid assimilation of American Indians.

Witness testimony indicates that urban Indians suffer an equally poor health status as their reservation-based families, but their access to health care services is in many cases much more difficult. There are 34 urban Indian health programs throughout the United States funded under Title V of the Indian Health Care Improvement Act. Many of these programs meet the basic health care needs for Indians in urban settings who would otherwise not receive care. Yet the funding and the resources for these programs is very modest in comparison to other IHS funded programs. For five years in a row during the first half of the 1980's the President's Budget sought to eliminate urban Indian health programs altogether. The Administration based its proposed elimination of funding for urban Indian health programs on the premise that other health care providers in urban areas could provide the health care currently provided by urban Indian health programs. Congress responded by requesting documentation of the capacity of other providers to absorb the urban Indian patient population into their caseloads, but the Administration could never produce any documentation of their premise. In the interim, the committees of Congress held hearings to explore whether non-Indian health centers based in urban areas could in fact provide care to the urban Indian population within their existing budgets, and found that in every instance, these centers and health care providers could not provide such care, even were they to receive additional funding. Finally, in 1986, the Administration acknowledged that there were no alternate health care sources for urban Indians, and resumed requesting minimal funding for the urban Indian health care programs. While Congress maintained urban Indian health clinics in the budget year after year, the effect of rising medical costs has diminished the overall purchasing power of urban Indian health programs.

The purchasing power of funds appropriated for urban Indian health has been reduced by 70 percent in the period from 1978 to 1988. While still drastically under-funded to meet the demand for care, the Indian Health Service experienced a net increase in its annual budget (adjusted for inflation) of 2 percent over the past ten years. In contrast, the Urban Indian Health Program, once adjusted for inflation, experienced a *net loss* in appropriations of 70 percent. This loss can be attributed to increasing costs of medical malpractice, professional staff salaries, medical supplies, pharmaceuticals, space costs, utilities, and other overhead costs, which have left urban programs unable to respond to the growth in urban Indian populations and their demand for health services.

Witness testimony noted that medical malpractice and professional liability insurance premiums have increased by as much as 500 percent for most urban health clinics while the purchasing power of funding has been decreasing. Without increased funding to meet these costs, many urban Indian clinics have had to discontinue prenatal care and in one case, all direct services. A recent study by the Institute of Medicine found that the high cost of medical malpractice was directly responsible for the sharp decrease in

prenatal and obstetrical services for rural and low income women in America. This same finding applies to the urban Indian projects, in that eight of the 34 urban Indian clinics in the country do not carry malpractice insurance due to its high cost. Eleven percent of the urban clinics have been turned down by insurers. It was also reported that over 26 percent of the urban clinics have reduced services to cover the cost of insurance, while five percent changed or eliminated prenatal and obstetrical care due to the cost of insurance.

Although the Fiscal Year 1990 adjusted appropriation for urban Indian health is \$13,049,000, this sum represents only 1 percent of the overall IHS budget. Even though the IHS funding for urban Indian health programs is very limited—Title V provides only 42.4 percent of the funding base—the urban Indian health programs work efficiently in managing their IHS funding and maximizing these resources to leverage other funds. These resources include third party reimbursements from Medicaid (5.4 percent), Medicare (.8 percent) and private insurance (3.8 percent). The programs also apply for other forms of Federal assistance and receive the following: Maternal Child Health funds (.6 percent); Section 330, Community Health Centers—PHS funds (10.3 percent); Women, Infants and Children funds (4.9 percent); Title X—Family Planning funds (0 percent); Title XX—Social Services Block Grant funds (0 percent) and other forms of Federal assistance (2.9 percent). Local governmental fund raising has yielded 6.3 percent from the states, 2.4 percent from the counties and 2.3 percent from the cities. Patient collections and fees for service account for 2.8 percent of the urban Indian health care budget. Finally, there are other IHS sources beside those funds secured under Title V, such as alcoholism programs, which provide for 10.7 percent of the urban Indian program funding.

In spite of the availability of these resources, the 34 urban Indian health clinics do not have the funding necessary to provide quality care. While there are extensive programs administered by the Indian Health Service to provide for the health care of those Indian people residing on reservations, relatively little has been done to extend these same services to the over 50 percent of the Indian population that resides in urban settings. The bill as amended would attempt to expand the range of services available to urban Indians to a level more consistent with those services generally available to other Indian Health Service patient populations.

As amended, S. 2645 would extend the following health services to urban Indians: health promotion and disease prevention; immunization; mental health; prevention and treatment of child abuse; and a facilities assessment to identify construction needs of urban Indian projects. These services are for the most part non-existent in urban Indian clinics. For example, the San Francisco Urban Indian Health Board testified that of the 47 women who had delivered a baby in the last year, 21 percent had received no prenatal care before delivery and 38 percent failed to obtain care in the first trimester. And despite the need for medical services, 37 percent of the population noted their source of care as the Emergency Room or "no usual place for care". The same holds true for mental health services. Of the few urban Indian health programs attempt-

ing to provide mental health counseling, the average number of patients per counselor has grown from 92 in 1985 to 207 clients per counselor in 1987 as reported by the American Indian Health Care Association.

Despite the limitations documented in the hearing record, the Committee is impressed with the efforts of the urban Indian health programs to meet the goals of the Indian Health Care Improvement Act and the initiative they have demonstrated over the past years. The urban Indian programs have developed and implemented a reporting system; developed and initiated AIDS education and prevention activities and alcohol and substance abuse prevention, treatment, rehabilitation and education programs; continued to improve linkages and cooperation with local agencies; decreased administrative costs; expanded services; and remained cost effective.

The urban Indian health programs have testified that lack of Administration support and the movement toward "privatization" has eroded accessible and affordable health care for urban Indians. Although S. 2645 has been introduced as an "equity" bill in the classic sense, the witnesses testified that S. 2645 will simply enable urban Indian programs to catch-up with an already over-taxed system of health care. Therefore, in order to sustain cost effectiveness, meet the needs of urban Indian and initiate equitable health care delivery, the Committee recommends enactment of S. 2645.

COMMITTEE AMENDMENT

S. 2645, entitled the Urban Indian Health Equity Act, as amended would expand the level of care to provide:

Health promotion and disease prevention services authorized at a level of \$500,000 for fiscal year 1991 and \$1,000,000 for fiscal years 1992, 1993 and 1994. The definition of health promotion and disease prevention is referenced under the Indian Health Care Improvement Act Amendment of 1988.

Immunization initiatives for infants, children and elderly authorized at a level of \$1,000,000 for fiscal year 1991 and \$2,000,000 for fiscal year 1992, 1993 and 1994. This section was expanded to include the elderly under the substitute.

Mental health services are authorized to allow urban Indian contractors to apply for grants for the following purposes: to conduct a mental health needs assessment, if none is available; to provide outreach, educational and referral services; to provide outpatient mental health services; and to develop innovative mental health service delivery models. The authorization for appropriations is \$2,500,000 for fiscal year 1991, \$5,000,000 in fiscal year 1992, \$7,500,000 for fiscal year 1993, and \$10,000,000 for fiscal year 1994.

Child abuse prevention and treatment services are authorized to provide grants for the following: to conduct needs assessments; for the development of prevention, training and education programs; and to provide direct outpatient treatment services in urban Indian communities. The authorization for appropriations is \$2,500,000 for fiscal year 1991; \$5,000,000 in fiscal year 1992; \$7,500,000 for fiscal year 1993, and \$10,000,000 for fiscal year 1994.

Services would include a facilities assessment which would require the IHS to conduct a survey of all facilities used by urban

Indian contractors and to report to Congress two years after enactment on these needs. The report shall address—the extent to which improvements, expansion, or relocation is necessary to meet JCAHO standards; lease restrictions; and site specific overall assessment of each urban Indian clinic. In the interim, the IHS may make funds available to urban projects for minor renovations to facilities, including leased facilities, to assist these projects in meeting or maintaining JCAHO standards. The authorizations for appropriations is \$2,500,000 for fiscal year 1991 and \$5,000,000 in fiscal year 1992, 1993, and 1994.

A report to Congress on urban Indian health which details the health status of the urban Indian population, services provided through this title, and areas of unmet needs. The IHS, as well as the BIA, is required to report on the status of Indian child welfare in urban Indian communities.

A new section has been added to establish within the Office of Health Programs of the IHS, a Branch of Urban Indian Health Programs to carry out the responsibilities of this program.

The total authorization of appropriations under the substitute to S. 2645 is \$9,000,000 in fiscal year 1991, \$18,000,000 in fiscal year 1992, \$23,000,000 in fiscal year 1993, and \$28,000,000 in fiscal year 1994.

OTHER CONSIDERATIONS

The urban Indian clinics testified that S. 2645 will address their most pressing needs and will do much to restore the 70 percent decrease in annual urban Indian health appropriations which has severely impaired the ongoing development of programs. It is recommended that the funding for urban Indian programs be appropriated over and above the base funding already appropriated or urban Indian programs.

Urban Indian programs have indicated that while county health departments may be able to provide many needed immunization services, they have found that their already taxed system, together with their inability to deal effectively with cultural barriers, results in a serious lack of access to health care services for Indian people. Section 4, paragraph (b) provides for a grant program of immunization and immunization services which shall take into consideration a number of factors, including the availability of alternative resources from state and local governments. The Committee recommends that the IHS closely examine these resources to determine if the system is overburdened and whether cultural barriers indeed prohibit effective delivery of care.

Section 4, paragraph (c) establishes a grant program to provide mental health services in urban Indian communities. Witness testimony revealed that urban Indian health programs were able to employ few mental health professionals, were not able to provide mental health services of adequate duration or intensity, and were not able to meet the need in the current patient population. A survey of urban Indians noted that 12 percent felt that anxiety and depression was a problem and 50 percent noted they had been unusually stressed, sad, or in need of counseling in the last year. Only 9 percent of the 50 percent felt that they received the help they needed and a total of 53 percent felt that if they needed help for an

emotional problem, they would not know where to go for help. This data emphasizes the lack of appropriate mental health services. The Committee recommends that the Urban Health Programs Branch established under Section 5 work closely with the Mental Health Programs Branch of the IHS to address these concerns.

The Committee concurs with the testimony which suggests that a coordinated, integrated, human service system which is accessible, culturally sensitive, and capable is the only rational way to deliver services to the special multi-need population of urban Indians. Therefore, the Committee recommends that each of the IHS programs vested with the responsibilities of Health Promotion and Disease Prevention; Immunization; Mental Health and Social Services; Alcoholism and Substance Abuse; and Maternal and Child Health work closely with the Urban Health Programs Branch to coordinate and enhance service delivery to urban Indian communities.

Section 4, paragraph (e) establishes a procedure for studying the facility construction needs of urban Indian programs and requires the IHS to report to the Congress on general recommendations for addressing the deficiencies identified in this study. The hearing record indicates that urban Indian facilities are severely antiquated and in a serious state of disrepair. The American Indian Health Care Association reports in its preliminary 1990 study of urban Indian clinics facility improvements needs that the total estimated cost is \$4,307,000. This amount of funding would allow the urban Indian health programs to comply with local building codes, meet clinic licensing requirements, pursue JCAHO accreditation, correct health and safety conditions, maintain services to current clients, relocate facilities as needed, and purchase necessary equipment. Many of the urban Indian health programs facilities require improvements to avoid code violations and to qualify for accreditation. Facility improvements would also increase patient flow, access, and increase the number of patients served by existing staff. The Committee recommends that the IHS Urban Health Programs Branch quickly identify those facilities which require minor renovations and work with the Office of Environmental Health and Engineering to implement paragraph (3) of this subsection.

Witness testimony indicates that the IHS has made little effort to document the health needs of urban Indians. The absence of data was recently emphasized in the 1986 report, *Indian Health Care*, published by the Office of Technology Assessment. More recently, in November of 1989 the American Indian Health Care Association completed the "Assessment of the Health Care Needs of the Urban Indian Population in the State of Arizona". This document reports that "the health status of urban Indians is poor". To address the problems of inadequate data, section 5 requires the IHS to report to the Congress in March of 1992, 1993 and 1994 on the health status of urban Indians, the services provided under Title V and areas of unmet needs. Further, the IHS and the BIA are required to report to the Congress on the status of Indian child welfare in urban communities by 1993. The Committee expects this information to be developed in close consultation with urban Indian health providers and the American Indian Health Care Association.

Finally, the Committee has been impressed with the initial success of the demonstration project in which two urban Indian clinics located in Tulsa and Oklahoma City, Oklahoma have been granted approval to be managed as Service Units under the IHS. This unique funding status has allowed the two Oklahoma clinics to access training, equipment, supplies, and technical assistance available through the IHS resulting in a considerable cost savings. Despite this unique status, the Committee does not intend to exclude the two Oklahoma clinics from participation in the programs authorized under the Urban Indian Health Equity Act.

LEGISLATIVE HISTORY

S. 2645 was introduced on May 16, 1990 by Senator Inouye and referred to the Select Committee on Indian Affairs. Additional cosponsors of the bill include: Senator DeConcini, Senator McCain, Senator Murkowski, Senator Moynihan, Senator Durenberger, and Senator Adams. A hearing on S. 2645 was held on July 19, 1990 which elicited the testimony of urban Indian Health projects, clinicians who serve urban and rural off-reservation communities and representatives of Indian and non-Indian health related organizations who advocate for quality health delivery. The bill was considered by the Select Committee in an open business session on September 18, 1990, and was ordered reported as amended.

In the House, Representatives Dicks and Campbell introduced H.R. 5005, a companion bill to S. 2645, on June 12, 1990. H.R. 5005 which was referred jointly to the Committee on Energy and Commerce and Interior and Insular Affairs. A hearing was held on July 31, 1990 by the Committee on House Interior and Insular Affairs. While the IHS testimony received by the House provided information on the health status of urban Indian populations, the statement did not present opposition to H.R. 5005. The primary concern raised by the Administration centered on the Facilities Improvement section of the bill which has been amended to address the issues raised by the IHS. H.R. 5005 was incorporated as a substitute amendment to S. 1270 by the House Committee on Interior and Insular Affairs and was ordered to be reported on September 19, 1990.

COMMITTEE RECOMMENDATION AND TABULATION OF VOTE

In open business session on September 18, 1990, the Select Committee on Indian Affairs, by a unanimous vote of a quorum present, ordered the bill, as amended, reported with the recommendation that the Senate Adopt the bill.

SECTION-BY-SECTION SUMMARY ANALYSIS

Section 1. Short Title

This Act may be cited as the "Urban Indian Health Equity Act".

Section 2. Findings

Congress finds that—

1. The urban Indian population as a result of Federal relocation initiatives represent up to 50 percent of the total American Indian

population and receives comparatively minimal assistance through the Indian Health Service (IHS).

2. The American Indian Policy Review Commission reported to the Congress that up to 160,000 Indian people were relocated under the Bureau of Indian Affairs (BIA) relocation program.

3. That one-half of the 1.7 million Indian people in the United States reside in urban areas.

4. Less than one percent of the IHS annual budget provides for health services to urban Indians.

5. Annual funding for urban Indian health programs has not been comparatively consistent with other IHS programs.

6. The purchasing power of annual appropriations for urban Indian health care has decreased by 70 percent from 1978 to 1988.

7. Urban Indian people suffer from the same low health status which affects Indian people on reservations caused primarily from lifestyle factors, including alcoholism, substance abuse, poor diet, family instability and mental health problems.

Section 3. Priority for Fund Expenditures

Section 3 provides that the priority for the expenditure of funds to be made available pursuant to this title shall be in accordance with section 503(a) of the Indian Health Care Improvement Act.

Section 4. Health Care Services for Urban Indians

(a) *Health Promotion and Disease Prevention.*—Section 4(a) amends section 503 of Title V of the Indian Health Care Improvement Act by adding a new subsection which provides that the Secretary, acting through the Indian Health Services, is to facilitate access to or provide health promotion and disease prevention services as defined in section 4 (k) and (l) of the Indian Health Care Improvement Act to urban Indians through grants with urban Indian organizations funding under section 503 (a) of the Indian Health Care Amendments Act of 1988.

The new section authorizes appropriations in the amount of \$500,000 for fiscal year 1991, and \$1,000,000 for each of the fiscal years 1992, 1993, and 1994 for the purpose of carrying out this section.

(b) *Immunization.*—Section 4 (b) further amends section 503 of the Indian Health Care Improvement Act by adding a new subsection which provides that the Secretary, acting through the Indian Health Service, is to facilitate access to or provide funding for immunization and immunization services for urban Indians through grants made to urban Indian health organizations administering contracts entered into pursuant to the new section. Funds may be made available for the following purposes: printing and dissemination of educational materials; purchase of vaccines and other supplies to provide immunization services to infants, children and the elderly; and staffing to deliver immunization services.

Section 4(b) further provides that in making grants to carry out the new section, the Secretary of Health and Human Services is to take into consideration, the size of the urban Indian population; immunization levels of the patient population; available alternate resources; and the capability of the organization.

Section 4(b) authorizes appropriations in the amount of \$1,000,000 for fiscal year 1991, and \$2,000,000 for each of the fiscal years 1992, 1993, and 1994 for the purpose of carrying out the new section.

(c) *Mental Health Services.*—Section 4(c) further amends Section 503 of the Indian Health Care Improvement Act by adding a new subsection which provides that the Secretary, acting through the Indian Health Service, is to facilitate access to, or provide mental health services to urban Indians through grants made to urban Indians organizations contracted under section 503(a) of the Indian Health Care Amendments Act of 1988.

Section 4(c) also provides that the Secretary, may make such grants—to conduct a mental health needs assessment of urban Indian communities, to assess the mental health needs in the community, the available resources, discrepancies in health services, and to develop and implement plans to improve health delivery; and to develop a plan to improve those services.

Section 4(c) provides that where an urban Indian organization has conducted a needs assessment as provided in paragraph (2) or where the Secretary has determined such organization has already developed such an assessment, the Secretary may make a grant to: provide outreach, education, and referral services to urban Indian populations providing a linkage to available direct services, educating the community about mental health issues and services, and networking to improve health delivery; to provide outpatient mental health services including identification, assessment, therapeutic treatment, case management, support groups, family treatment, and other services; and to develop innovative mental health service delivery models which incorporate cultural support systems and resources.

Section 4(c) authorizes appropriations in the amount of \$2,500,000 for fiscal year 1991, \$5,000,000 for fiscal year 1991, \$7,500,000 for fiscal year 1993, and \$10,000,000 for fiscal year 1994 for the purpose of carrying out the subsection.

(d) *Prevention and Treatment of Child Abuse.*—Section 4(d) further amends Section 503 of the Indian Health Care Improvement Act by adding the following new subsection which provides that the Secretary, acting through the Indian Health Service, shall facilitate access to or provide grants to urban Indian organizations contracting under section 503(a) of the Indian Health Care Amendments Act of 1988, to prevent and treat child abuse (including sexual abuse) in urban Indian communities. Funds may be made available: (1) to conduct a needs assessment as required by paragraph (2)(c) of the subsection; (2) for the development of prevention, training, and education programs targeted at urban Indian communities, to include: child education, parent education, provider training on identification and intervention, education on reporting requirements, prevention campaigns, and the establishment of service networks of all those involved in child protection; and (3) to provide direct outpatient treatment services to child victims of sexual abuse, adult survivors of child sexual abuse, families of child victims, and perpetrators of child abuse (including sexual abuse) in urban Indian communities, to include: individual mental health

treatment, family mental health treatment, group therapy, and support groups.

Section 4(d) provides that in making grants to carry out this subsection the Secretary shall into consideration, the following: the urban Indian organization must demonstrate support from the child protection authorities in the area, including committees or other services funded under the Indian Child Welfare Act; the urban Indian organization must demonstrate the capability and expertise to address the complex problem of child sexual abuse in its community; and a needs assessment, submitted by the urban Indian organization before requesting funding under this subsection, which documents the prevalence of child abuse in the Indian community and the proposed services which do not duplicate existing services and which are approved by the IHS.

Section 4(d) authorizes appropriations in the amount of \$2,500,000 for fiscal year 1991, \$5,000,000 for fiscal year 1992, \$7,500,000 for fiscal year 1993, and \$10,000,000 for fiscal year 1994 to carry the subsection.

(e) *Facilities Assessment.*—Section 4(e) further amends Section 503 of the Indian Health Care Improvement Act by adding a new subsection which provides that the Secretary is to conduct a survey of all facilities used by a contractor under this title and is to submit a report to the Congress on such survey within 2 years of the date of enactment of the Act. The report is to contain, at a minimum, the following for each location: the extent to which the facility meets safety and building codes and, if direct care is provided, the extent of compliance with Joint Commission for Accreditation of Health Care Organizations (JCAHO) standards; the extent to which improvements, expansion, or relocation is necessary to meet program requirements, provide adequate services, or achieve building code compliance; any lease restrictions that would hamper accomplishment of needed improvement, expansion or relocation; the term of the lease, if appropriate, the age of the building, and the building's life expectancy with or without improvement; and site specific overall assessments.

Section 4(e) provides that the report shall include recommendations for addressing the deficiencies of facilities and shall propose program policies for accomplishing those recommendations.

Section 4(e) authorizes the Secretary to make funds available to contractors under this title for minor renovations to facilities including leased facilities, to assist such contractors in meeting JCAHO standards.

Section 4(e) authorizes appropriations in the amount of \$2,500,000 for fiscal year 1991 and \$5,000,000 for each of the fiscal years 1992, 1993 and 1994 to fulfill the requirements of the section.

Section 5. Reports

Section 5 amends Section 507 of title V of the Indian Health Care Improvement Act by adding at the end a new subsection which provides that the Secretary, acting through the Indian Health Service, is to submit to Congress no later than March 1992, 1993 and 1994 a report evaluating the health status of the urban Indian population, the utilization of health services by urban Indi-

ans through this title, and areas of unmet need, including urban areas not served pursuant to this Act.

Section 5 provides that in preparing this report, the Secretary is to consult with Urban Indian health providers and may contract with a national organization representing urban Indian health concerns to conduct any aspect of the report.

Section 5 further provides that the Secretary of Health and Human Services and the Secretary of Interior shall report to Congress no later than March 1993 their assessment of the status of Indian child welfare in urban Indian communities, including information on the volume of child protection cases, the prevalence of child sexual abuse, the extent of urban coordination with tribal authorities, and their recommendations to improve Indian child protection in urban communities.

Section 6. Urban Health Programs Branch

Section 6 amends Title V of the Indian Health Care Improvement Act by adding at the end a new section which provides for the establishment of an Office of Health Programs of the IHS, as a part of the Division of Clinical and Preventive Services, a Branch of Urban Health Programs which is to be responsible for carrying out the provisions of this title.

Section 6 also provides that the Secretary is to appoint such employees to work in the Branch, including a Program Director, and is to provide services and equipment needed to carry out its responsibilities. The Secretary is to also analyze the need to provide at least one urban health program analyst in each IHS area office and shall submit such findings as a part of the IHS fiscal year 1993 Budget request.

COST AND BUDGETARY CONSIDERATION

The Cost estimate for S. 2645, as provided by the Congressional Budget Office is set forth below:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, September 24, 1990.

HON. DANIEL K. INOUE,
Chairman, Select Committee on Indian Affairs, U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached cost estimate for S. 2645, the Urban Indian Health Equity Act, as ordered reported by the Senate Select Committee on Indian Affairs on September 18, 1990.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

ROBERT D. REISCHAUER,
Director.

CONGRESSIONAL BUDGET OFFICE—COST ESTIMATE

1. Bill number: S. 2645.
2. Bill title: Urban Indian Health Equity Act.

3. Bill Status: As ordered reported by the Senate Select Committee on Indian Affairs on September 18, 1990.

4. Bill purpose: To amend the Indian Health Care Improvement Act to improve the health status of the urban Indian population and to enhance the quality and scope of health care services, disease prevention activities and health promotion initiatives targeted at the urban American Indian population.

5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1991	1992	1993	1994	1995
Estimated Authorization Levels:					
Health Promotion	0.5	1.0	1.0	1.0	
Immunization	1.0	2.0	2.0	2.0	
Mental Health Services	2.5	5.0	7.5	10.0	
Child Abuse Prevention	2.5	5.0	7.5	10.0	
Facilities Assessment	2.5	5.0	5.0	5.0	
Reports	0.7	0.3	0.3		
Urban Health Programs Branch	0.3	0.3	0.5	0.5	0.5
Total Estimated Authorization Levels	9.9	18.5	23.8	28.5	0.5
Total Estimated Outlays	7.9	16.3	22.3	27.3	5.5

Details in this table may not add to totals because of rounding. The costs of this bill fall within budget function 550.

Basis of estimate

S. 2645 would authorize federal funds to provide health promotion and disease prevention services, immunizations, mental health services, and child abuse prevention and treatment services to urban Indians. In addition, the bill would authorize the Secretary of Health and Human Services (HHS) to conduct a survey of all urban health facilities affected by this legislation and to provide funds to those facilities that need minor renovations. Authorization levels for these provisions are specified in the bill.

S. 2645 would authorize the Secretary of HHS to report to Congress in March of 1992, 1993, and 1994 on the health status of Indians in urban areas. In addition, the bill would authorize the Secretary of HHS to report to Congress by March 1993 on the status of Indian child welfare in urban communities. Based on information provided by the Indian Health Service (IHS), CBO estimates that the health status reports would cost \$250,000 per year, and that the Indian child welfare report would cost a total of \$400,000.

The bill would establish a Branch of Urban Health Programs within IHS. The Secretary of HHS would be required to analyze the need to provide one urban health program analyst in each of IHS's area offices and to submit his findings in the fiscal year 1993 budget request. Based on information provided by IHS, CBO estimates it would cost about \$250,000 in each of fiscal years 1991 and 1992 to establish and maintain a central branch, and \$500,000 in fiscal years 1993 to 1995 to maintain a central branch as well as support an urban health program analyst in each of the area offices.

This estimate assumes that all authorizations are fully appropriated at the beginning of each fiscal year. Outlays are estimated using spendout rates computed by CBO on the basis of recent program data.

6. Estimated cost to State and local government: None.
7. Estimate comparison: None.
8. Previous CBO estimate: None.
9. Estimate prepared by: Karen Graham (226-2820).
10. Estimate approved by: C.G. Nuckols (for James L. Blum, Assistant Director for Budget Analysis.)

REGULATORY IMPACT STATEMENT

Paragraph 11(b) of Rule XXVI of the Standing Rules of the Senate requires each report accompanying a bill to evaluate the regulatory and paperwork impact that would be incurred in carrying out this bill. The Committee believes that S. 2645 will have minimal regulatory or paperwork impact.

EXECUTIVE COMMUNICATIONS

The substitute bill was forwarded to the Administration for their formal views and comments on July 24, 1990. Set forth below is the response:

SECRETARY OF HEALTH
AND HUMAN SERVICES,
Washington, DC, September 18, 1990.

Hon. DANIEL K. INOUE,
Chairman, Select Committee on Indian Affairs, U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: This is in response to your request for a report on S. 2645, a bill "To improve the health status of the urban Indian population and to enhance the quality and scope of health care services, disease prevention activities, and health promotion initiatives targeted at the urban American Indian population."

S. 2645 would direct the Secretary of Health and Human Services to enter into contracts with urban Indian organizations (or make grants, in the case of mental health services) for carrying out health promotion and disease prevention activities, for immunizations, for the provision of mental health services, for the prevention and treatment of child sexual abuse, and for the renovation, expansion, or relocation of facilities and for the purchase of equipment.

Current law already directs the Secretary to enter into Indian health care contracts with urban Indian organizations. The emphasis is on assuring appropriate referral to and coordination among existing health care providers in the provision of health care to urban Indians. S. 2645 appears to suggest that we should support a separate, parallel system of health care for Indians in urban areas. Such duplication would not be cost-efficient.

Most urban Indian organizations rent, rather than own, their premises. In these circumstances we do not believe that funding for facility renovation, expansion, or relocation is desirable.

In a period of budgetary constraints, we believe that we must continue to focus our limited resources primarily on Indians residing on reservations, where no other resources are available.

We therefore recommend that the bill not be favorably considered.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

LOUIS W. SULLIVAN, M.D.,
Secretary.

CHANGES IN EXISTING LAW

In compliance with subsection 12 of Rule XXVI of the Standing Rules of the Senate, it is the opinion of the Committee that it is necessary to dispense with the requirements of subsection 12 to expedite the business of the Senate.

○